



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  PRESBYTERIAN HOSPITAL OF DALLAS 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-07-3752-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  EAST TX EDUCATIONAL INS ASSN Box #: 11	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We have filed an MDR for this service because we believe that the reimbursement received for this trauma admit (Dx 836.0) was not Fair and Reasonable. Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare APC rate for this service is \$2923.19 (\$1670.30 for APC 41 @ 100% for primary procedure + 50% for secondary procedure + 25% for tertiary procedure) times 140% is \$4092.47. We only received \$1000.00 in payment for this service-seriously below even the APC rate alone. We request that the carrier pay the remaining balance due of \$3092.47."

**Amount in Dispute:** \$3092.47

### PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/27/2006	16, 42, 97, 243, 285, W1, 295	Outpatient Surgery for Trauma Admit	\$3092.47	\$0.00
<b>Total Due:</b>				\$0.00

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on February 20, 2007.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
  - 42-Charges exceed our fee schedule or maximum allowable amount.
  - 97-Payment is included in the allowance for another service/procedure.
  - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
  - 285-Please refer to the note above for a detailed explanation of the reduction.
  - W1-Workers compensation state fee schedule adjustment.

- 295-Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.
2. Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 836.0. The Division therefore determines that this outpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1 and Texas Labor Code §413.011(d).
  3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
  4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
  5. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all medical bill(s)... as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration..." Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(A).
  6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
  7. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
    - The requestor's position statement states that: "We have filed an MDR for this service because we believe that the reimbursement received for this trauma admit (Dx 836.0) was not Fair and Reasonable. Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare APC rate for this service is \$2923.19 (\$1670.30 for APC 41 @ 100% for primary procedure + 50% for secondary procedure + 25% for tertiary procedure) times 140% is \$4092.47. We only received \$1000.00 in payment for this service-seriously below even the APC rate alone. We request that the carrier pay the remaining balance due of \$3092.47."
    - The requestor does not discuss or explain how payment of 140% of Medicare rate would result in a fair and reasonable reimbursement.
    - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
    - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
    - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
    - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311  
28 Texas Administrative Code §133.307, §134.1, §134.401  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **DECISION:**

_____	_____	9/16/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**